



## Request for Service Credit Cost Information Leave of Absence

### Section A: Documentation of Service (to be completed by member)

Have you requested this cost information before? ☐ Yes ☐ No If yes, list date request was submitted: \_\_\_\_\_

Have you submitted a retirement application? ☐ Yes ☐ No If yes, list retirement date: \_\_\_\_\_

### Part 1 Member Information

Name	Social Security Number		
Former Name (if applicable)	Current Employer		
Daytime Phone			
Mailing Address	City	State	ZIP

### Part 2 Employment Information

List the name and address of the employer that granted the leave.

Employer			
Employer Address	City	State	ZIP

Dates of Leave		Type/Purpose of Leave
From (mo./day/year)	To (mo./day/year)	
		Maternity/Paternity, Educational, Service, Sabbatical, Temporary Disability

### Part 3 Certification

I hereby certify that the above information is true and correct.

Member Signature	Date
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- Sign and date the request form and give it to the employer that granted the leave for completion of Section B (and for routing to compensation carrier to complete Section C, as appropriate) before returning to CalPERS.

**Mail To: CalPERS Member Services Division, P.O. Box 4000, Sacramento, CA 95812-4000**

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

## Section B: Leave of Absence Certification (to be completed by employer)

### Part 1 Leave Type and Dates

Verify Type of Leave: ☐ Maternity/Paternity ☐ Educational ☐ Service ☐ Sabbatical ☐ Temporary Disability

Approved Dates of Leave from (month/day/year): \_\_\_\_\_ to (month/day/year): \_\_\_\_\_

### Part 2 Statement and Signature of Authorized Employer Representative

I hereby certify that the above information is true and correct.

Employer Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Telephone Number \_\_\_\_\_ FAX Number \_\_\_\_\_

**Employer: Please return the completed form to the member or forward it to the member's temporary disability carrier, as appropriate**

## Section C: Temporary Disability Leave of Absence Certification

This section is to be completed by the member's disability carrier (**only** for employees of the University of California, CalPERS-covered agencies, and schools).

### Part 1 Temporary Disability Carrier Information

Name of Employer's Disability Carrier \_\_\_\_\_

Carrier's Address \_\_\_\_\_ Carrier's Telephone Number \_\_\_\_\_

Employee's Claim Number\* \_\_\_\_\_ Beginning Date of Temporary Disability Payments \_\_\_\_\_ Ending Date of Payments \_\_\_\_\_

Effective Date of Permanent Disability Rating\* \_\_\_\_\_

Was there a settlement by Compromise and Release? ☐ Yes ☐ No (If yes, provide a copy.)

### Part 2 Signature of Authorized Temporary Disability Carrier Representative

Carrier Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Title \_\_\_\_\_

\*If there was more than one temporary disability leave period, provide claim number and dates for each.

**Temporary Disability Carrier: Please return the completed form to the member.**